THE NURSING PROCESS OUTLINE

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## The Nursing Process: Learning Outcomes

* **Learning Outcomes**

**Critical Thinking**

1. Describe the significance of developing critical-thinking abilities.
2. Discuss the skills and attitudes of critical thinking.
3. Explore ways of developing critical thinking skills.  
     
   **Assessing**
4. Describe the phases of the nursing process.
5. Identify the four major activities associated with the assessing phase.
6. Differentiate between objective and subjective data.
7. Describe each method of data collection
8. Contrast various frameworks used for nursing assessment  
     
   **Diagnosing**
9. Write nursing diagnosis statements following guidelines and steps  
     
   **Planning**
10. Describe activities that occur in the planning process
11. Design a plan of care following guidelines
12. Verbalize how to prioritize care
13. Write goals/desired outcomes following guidelines
14. Write appropriate individualized nursing interventions following criteria for choosing  
      
    **Evaluating**
15. Identify guidelines and skills for implementing nursing interventions
16. Describe five components of the evaluation process
17. Write an evaluation statement correctly
18. Describe the steps involved in reviewing and modifying the client’s care plan
19. Describe processes used to evaluate overall quality of nursing care

## The Nursing Process: Critical Thinking

**Kozier Ch. 10 – Critical Thinking and Nursing Practice**

**PPT – Critical Thinking and the Nursing Process**

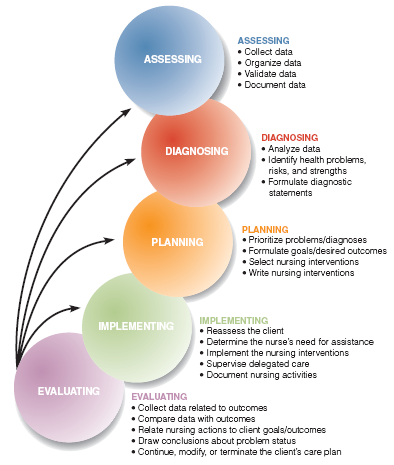
* **Critical thinking in nursing practice: Definition**
  + **Critical thinking in nursing practice: Definition**
    - “Active, cognitive process used to carefully examine one’s thinking & the thinking of others.”
  + NLN (2000)
    - “A discipline specific, reflective reasoning process that guides a nurse in generating, implementing & evaluating approaches for dealing with client care & professional concerns.”
* **Significance of Developing Critical Thinking** 
  + Essential for safe, competent, skillful nursing practice
  + Rapid and continuing growth of knowledge
  + Make complex and important decisions
  + Draw meaningful information from other subject areas
  + Work in rapidly changing, stressful environments
  + Recognize important cues, respond quickly, and adapt interventions
* **Top 10 Reasons to Improve Thinking** 
  + 10 - Things change
  + 9 - Sicker clients
  + 8 - More consumer involvement
  + 7 - Need to move from one setting to another
  + 6 - Need for new learning and workplace skills
  + 5 - Requirement for evidence of benefits, efficiency, and results
  + 4 - New problems can’t be solved with old ways of thinking
  + 3 - Thinking skills needed to deal with today’s world
  + 2 - Possible to improve thinking
  + 1 - Difference between success and failure

* **Creativity**
  + Major component of critical thinking
  + Thinking resulting in development of new ideas & products.
  + Ability to develop new & better solutions
* **Critical Thinking Skills**
  + Critical analysis (See Box 10-2)
  + Inductive and deductive reasoning
  + Making valid inferences
  + Differentiating facts from opinions
  + Evaluating the credibility of information sources
  + Clarifying concepts
  + Recognizing assumptions
* **Critical Thinking Attitudes** 
  + Independence
  + Fair-mindedness
  + Insight
  + Intellectual humility
  + Intellectual courage to challenge status quo / rituals
  + Integrity
  + Perseverance
  + Confidence
  + Curiosity
  + **See Box 10-2 for more CT characteristics**
* **Critical Thinking and Nursing** 
  + Critical thinking underlies each step of the nursing, problem-solving, and decision-making processes
  + **Problem-Solving Process**
    - Clarify the nature of a problem and suggests possible solutions
    - Evaluate solutions and choose best one to implement
      * Then carefully monitor the situation to ensure its effectiveness
    - Commonly used approaches
      * Trial and Error
        + Trying a number of approaches until the solution is found
        + This can be dangerous – inappropriate approaches can cause harm to clients
      * Intuition
        + Understanding or learning things without conscious use of reasoning – “I had a hunch…”
        + This MUST be coupled with thorough nursing knowledge and experience – otherwise, intuition is an inappropriate basis for nursing decisions
      * Research process
        + Logical, systematic approach (evidence-based practice)
        + Scientific method
  + **Decision-Making Process (See Table 10.3, it’s a great example)**
    - Choosing the best actions to meet a desired goal
      * Identify purpose
      * Set and weigh criteria
        + Use various priority assessment frameworks (i.e. – Maslow’s)
        + Determine what needs to be preserved/avoided
      * Seek and examine alternatives
      * Project, implement, and evaluate outcome
  + **Obstacles to Critical Thinking**
    - Overuse of habit mode
    - Severe anxiety
    - Working under deadlines
    - Over commitment to ideological, religious or political principles
    - Lack of confidence in one’s thinking
  + **Ways to develop critical thinking skills**
    - Rigorous personal assessment
    - Reflection
    - Cultivation of critical thinking abilities
      * Tolerate dissonance & ambiguity
    - Seeking situation where good thinking is practiced (conferences etc)
      * Awareness of own thinking-while thinking
    - Creating environments that support critical thinking

## The Nursing Process: Assessing

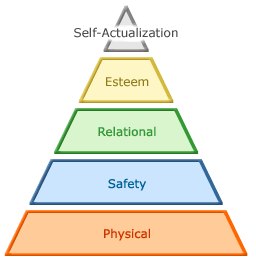
**Kozier Ch. 11 – Assessing  
PPT – Critical Thinking and the Nursing Process**

* **Nursing Process**
  + Systematic method of planning and providing individualized care
  + Characteristics:
    - Cyclical / dynamic
    - Client-centered
    - Focuses on problem solving & decision making
    - Interpersonal & collaborative
    - Universal application
    - Uses critical thinking (see Table 11-2)
  + Purpose:
    - to identify a client’s health status and actual or potential health care problems or needs
    - to establish plans to meet the identified needs
    - to deliver specific nursing interventions to meet those needs
* **Nursing Process: Components (See table 11-1)**
  + Assessment
  + Nursing Diagnosis
  + Planning
  + Implementation
  + Evaluation



* **Assessment Activities** 
  + Collecting data
  + Organizing data
  + Validating data
  + Documenting data
* **Types of Assessments** 
  + Initial
  + Problem-Focused
  + Emergency
  + Time-lapsed



* **Types of data**
  + SUBJECTIVE
    - What the client says (symptoms) lol
    - i.e. – “I feel dizzy.”
  + OBJECTIVE
    - What you see (signs)
    - i.e. – vomited 100mL green-tinged fluid.
      * medical record
      * diagnostic tests
      * Physical exam
        + inspection
        + auscultation
        + Palpation
        + percussion
      * USE YOUR SENSES
* **Sources of Data** 
  + Primary Source
    - Client
      * This is the best source of data (unless the client is too ill, young, or confused to communicate clearly)
      * If the client is for whatever reason unwilling to share data, remind her or him that clients’ privacy is protected by HIPAA (so we should all be familiar with it)
  + Secondary (Indirect) Sources
    - All other sources of data
      * Family, or other support persons
      * Records/reports
      * Lab results
    - should be validated, if possible
* **Methods of Data Collection**
  + Interview
  + Observation
  + Examination
  + **Interviewing**
    - Planned communication or a conversation with a purpose
    - Approaches
      * Directive
        + Highly structured, elicits specific info
        + Used when time is limited (emergency)
      * Non-directive (Rapport-building)
        + Client controls the purpose, subject matter, and pacing
      * Combination approaches usually appropriate
    - Type of interview questions
      * Closed–ended Question
        + Restrictive
        + Yes/no
        + Factual
        + ↓ effort and info
      * Open-ended Question
        + Invite longer answers, more info
        + Broad topic
        + “How have you been feeling lately?”
      * Neutral
        + Can answer w/o direction /pressure
        + Open ended
        + Non-directive
      * Leading
        + Directs client’s answer
        + Closed-ended
        + Directive
    - The Interview Setting
      * Time
      * Place
      * Seating arrangements
      * Distance
      * Language
  + **Observing**
    - Gathering data using the senses
    - Used to obtain following types of data:
      * Skin color (vision)
      * Body or breath odors (smell)
      * Lung or heart sounds (hearing)
      * Skin temperature (touch)
  + **Examining (physical examination)**
    - Systematic data-collection method
    - Uses observation and inspection, auscultation, palpation, and percussion
      * Blood pressure
      * Pulses
      * Heart and lungs sounds
      * Skin temperature and moisture
      * Muscle strength
* **Frameworks for Organizing Data** 
  + Nursing Models Framework
    - Gordon’s functional health pattern framework (See Box 11-4)
    - Orem’s self-care model (Box 11-5)
    - Roy’s adaptation model (Box 11-6)
* **Frameworks for Nursing Assessment** 
  + Wellness Models
  + Non-nursing Models
    - Body systems model
    - Maslow’s Hierarchy of Needs
    - Developmental theories
* **Validating Data**
  + Double check / verify for accuracy & factualness.
* **Documenting Data**
  + Accurately record data.

## The Nursing Process: Diagnosing

**Kozier Ch. 12 – Diagnosing**

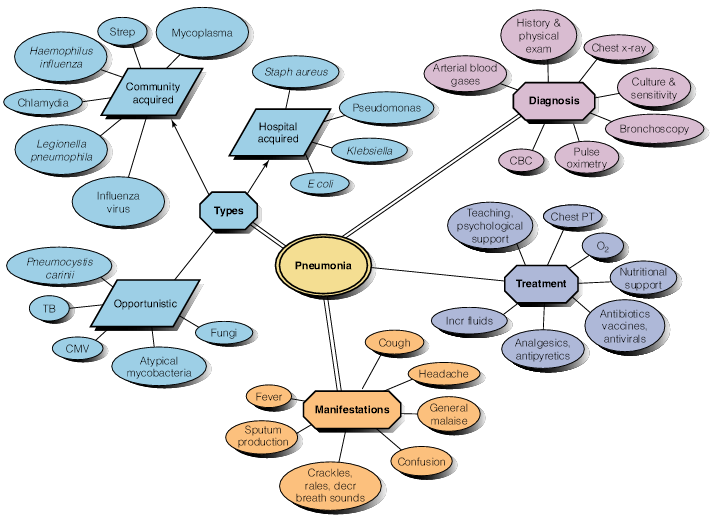
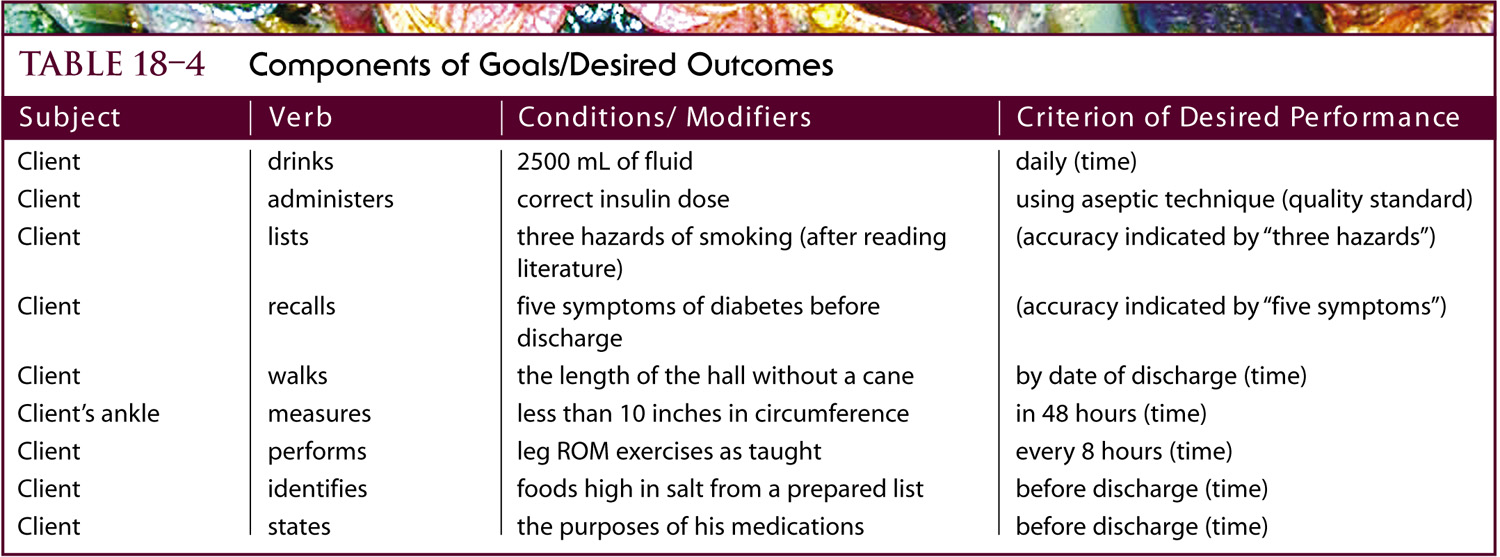
**PPT – Critical Thinking and the Nursing Process**

* **Nursing Diagnosis** 
  + Diagnosing – a reasoning process
    - Analyze data
    - Identify health problems, risks, and strengths
    - Formulate diagnostic statement
  + A nursing diagnosis is a client problem that can be treated primarily by independent nursing interventions
  + Implementing a nursing diagnosis provides the basis for selecting nursing interventions
* **North American Nursing Diagnosis Association (NANDA)**
  + Standardized language
  + Has evolved & continues to evolve.
  + Nsg dx
  + NOC (nursing outcomes)
  + NIC (nursing interventions)
* **Nursing Diagnosis Definition**
  + “A clinical judgment about individuals, family, or community responses to actual or potential health problems or life processes.”
* **Types of Nursing Diagnoses**
  + Actual Diagnosis
    - Existing
  + Risk Diagnosis
    - Potential
  + Wellness Diagnosis
    - Readiness for enhancement
  + Possible Diagnosis
    - Evidence incomplete/ unclear
  + Syndrome Diagnosis
    - Associated with a cluster of other diagnoses
* **Components of Nursing Diagnosis** 
  + Problem statement (diagnostic label)
    - Health problem / response
  + Etiology (related factors and risk factors)
    - 1 or more probable causes of problem
  + Defining characteristics
    - S/s (signs and symptoms) indicating presence of problem (actual diagnoses)
    - Factors causing more vulnerability to problem (risk diagnoses)
  + NOT THE SAME AS A MEDICAL DIAGNOSIS
* **Nursing Diagnoses (Table 12-3)** 
  + Describes human responses
  + Client-oriented
  + Nurse’s responsibility
  + May change frequently
  + Classification system in development
* **Medical Diagnoses** 
  + Describes disease and pathology
  + Does not consider human responses
  + Pathology -oriented
  + Physician’s responsibility
  + Nurse implements orders / monitors client
  + Nursing actions dependent
  + Remains as long as disease present
  + Well-developed /accepted classification
* **Collaborative Problems** 
  + Physiologic complications of disease, tests, treatments
  + Pathophysiology-oriented
  + Nurse and physician diagnose
  + Physician orders definitive treatment
  + Independent nursing action for monitoring and preventing
  + Dependent nursing actions for treatment
  + Present when disease/situation present
  + No classification system
  + EXAMPLE:
    - Nursing Diagnosis: Activity Intolerance related to decreased cardiac output
    - Medical Diagnosis: Myocardial Infarction
    - Collaborative Problem: Potential complication of myocardial infarction: congestive heart failure
      * The physiological complication of an MI
      * Statement of situation/Pathophysiology, and potential complication
* **Steps in Diagnostic Process** 
  + Analyzing Data
    - Compare data against standards
      * i.e. – compare the client’s blood levels with normal ranges
    - Cluster cues
      * Finding patterns/relatedness of information
      * Determining significance
    - Identify gaps and inconsistencies
  + Identifying health problems, risks, and strengths
  + Formulating diagnostic statements
* **Writing Nursing Diagnoses** 
  + Basic Two-Part Statement
    - Problem (P): statement of the client’s response
    - Etiology (E): factors contributing to or probable causes of the responses
    - Example: constipation related to prolonged laxative use
      * P: constipation
      * E: prolonged laxative use
  + Basic Three-Part Statement (recommended for beginners like us!)
    - Problem (P): statement of the client’s response
    - Etiology (E): factors contributing to or probable causes of the responses
    - Signs and symptoms (S) : defining characteristics manifested by the client
    - Example: Impaired skin related to immobility as manifested by Stage I pressure ulcer on the sacral area
      * P: Impaired skin
      * E: immobility
      * S: Stage I pressure ulcer on the sacral area
  + One-Part Statement
    - Wellness
      * Write “readiness for enhanced \_\_\_”
      * Example: Readiness for enhanced Spiritual Well-Being
    - Syndrome
      * A diagnosis related to a cluster of diagnoses
      * Example: Risk for Disuse Syndrome
        + …which can be a result of impaired physical mobility, impaired gas exchange, etc, etc
  + Variations
    - * Unknown etiology
        + Example: noncompliance (medication regimen) related to unknown etiology
      * Complex factors
        + Example: chronic low self-esteem related to complex factors
        + These factors are too numerous/complex to state
      * Possible
        + “Possible” can describe either the problem or the etiology
        + Example: Altered thought processes possibly related to unfamiliar surroundings
      * Secondary
        + Adds a more descriptive second part to the etiology
        + Example: Impaired Skin Integrity related to immobility secondary to CVA
      * Other additions for precision
        + You can add clarifiers to make a more precise statement, such as the location of the problem: Impaired Skin Integrity (Left scapula)
* **Guidelines for Writing a Diagnostic Statement (Table 12-6)** 
  + State in terms of problem, not need.
  + Word statement so it’s legally advisable.
  + Use nonjudgmental statements.
  + Make sure that both elements of statement don’t say same thing.
  + Be sure cause and effect correctly stated.
  + Word specifically and precisely
  + Use nursing terminology rather than medical terminology

## The Nursing Process: Planning

**Kozier Ch. 13 – Planning**

**PPT – Critical Thinking and the Nursing Process**

* **Planning** 
  + Prioritizing problems/diagnoses
  + Formulating client goals/desired outcomes
  + Selecting nursing interventions
  + Writing individualized nursing interventions
  + Planning is basically the nurse’s responsibility
    - but input from the client and support persons is essential if a plan is to be effective
* **Types of Planning**
  + Initial
  + Ongoing
  + Discharge
  + Multidisciplinary
  + Client participation
* **Types of Care Plans**
  + Informal
    - A strategy for action that exists in the nurse’s mind – “My patient is very tired; I need to reinforce her teaching when she’s gotten some rest.”
  + Formal
    - An organized plan for the client’s care
    - A ***major*** benefit of this is that it provides continuity of care
  + Standardized
    - A formal plan for a group of clients with common care needs (i.e. – MI patients)
  + Individualized
    - This is the best type of plan!
    - Tailored to the specific client – goes beyond the needs addressed by standardized plans
* **Standardized Plans**
  + Standards of care (Figure 13-3)
  + Standardized care plans (Figure 13-4)
    - Can be individualized.
  + Protocols
  + Policies and procedures
* **Formats for Nursing Care Plans**
  + Student care plans
  + Concept maps
  + Computerized care plans
  + Multidisciplinary (collaborative) care plans
    - Also called critical pathway
* **Example of Concept Map** 
  + 
* **Guidelines for Writing Nursing Care Plans** 
  + Date and sign
  + Use category headings
  + Use standardized/ approved terminology / symbols / key words
  + Be specific
  + Refer to procedure book or other sources rather than including steps
  + Tailor plan to client
  + Include:
    - prevention / health maintenance
    - interventions for ongoing assessment
    - collaborative and coordination activities
    - discharge plans and home care
* **The Planning Process: Activities**
  + Setting priorities- what’s most important.
    - Consider:
      * client’s health values beliefs
      * Client’s priorities
      * resources available to the nurse & client
      * urgency of the health problem
      * medical treatment plan
  + Establishing goals / desired outcomes
  + Selecting individualized nursing interventions
  + Writing individualized nursing interventions on care plans
* **Goals/Desired Outcomes** 
  + What the nurse wants to achieve
  + Demonstrates problem resolution
  + Purposes
    - Direction for planning interventions
    - Criteria for evaluating progress
    - Determination of problem resolution
    - Motivate by providing a sense of achievement
  + Short / long term
* **Establishing Client Goals/Desired Outcomes** 
  + NANDA’s Nursing Outcomes Classification (NOC)
    - Taxonomy for describing client outcomes
    - Similar to a goal in traditional language
    - Broadly stated and conceptual
    - Made more specific by identifying indicators that apply to client
    - Includes a five-point scale (a measure) used to rate the client’s status
  + Components of Goal/Desired Outcome Statements
    - Subject
    - Verb
    - Condition or modifier
    - Criterion of desired performance
      * “Client will walk the length of the hall unassisted by 9/15.”
* **Guidelines for Writing Goals/Desired Outcomes** 
  + Client centered
  + Must be realistic
  + Ensure compatibility with the therapies of other professionals
  + Derive from only one nursing diagnosis
  + Use observable, measurable terms
  + Considered important by client
  + Mutually agreed upon
  + The RN should:
    - Date & sign the plan
    - Use category headings
    - Use approved symbols & key words (instead of writing out complete sentences)
    - Be specific
    - Refer to procedure books or other sources of information rather than including all the steps (Professor Stypolkowski doesn’t actually agree with this one)
    - Customize the plan to accommodate the patient’s needs/wishes
    - Ensure that it incorporates preventive and health maintenance aspects (not just health restoration)
    - Include ongoing assessment plans
    - Include collaborative and coordination activities (i.e. – conferring with a specialist)
    - Include plans for discharge and homecare needs
* **PRACTICE**
  + The client will:
    - Feel better each day
      * Broad/subjective
      * Better: “Decrease in reports of pain; none within 8 hours”
    - Understand diabetes mellitus by discharge
      * Broad/subjective
      * Better: “Recall 5 symptoms of diabetes before discharge”
    - **Drink 800cc of fluid between 7am and 7pm**
      * **Good!**
    - Report decreased pain
      * Ok, but no timeframe given…
    - Improve her relationship with her husband
      * Broad
      * Better: “Client and husband communicating effectively and working together to solve problems.” (see p. 226)
    - **Demonstrate the correct use of crutches on flat surfaces and stairs by discharge**
      * **Good!**
* **PRACTICE GOALS**
  + The patient’s hydration will improve.
    - It’s ok to be broad with goals, as long as they are clarified with specific outcomes: “…as evidenced by…” see Kozier p. 223
    - i.e.: “The patient‘s hydration status will improve as evidenced by good skin turgor and moist mucous membranes within 24 hours.”
  + **The patient will verbalize decreased pain within an hour of pain medication.**
    - **Good! Contains subject, verb, conditions, and time.**
  + The patient will ambulate.
    - Better: “the patient will ambulate [specific distance] by [specific time]”
  + The patient will learn about good nutrition.
    - This goal might not be realistic – also, learning about “good” nutrition does not ensure compliance with the best nutritional plan for the particular patient.
    - It’d be better to say, for example: “The patient will discuss the food pyramid and recommended daily servings before discharge.”
    - Or: “The patient will identify foods high in salt from a prepared list before discharge”
* **Nursing Interventions and Activities** 
  + Actions to achieve goals/desired outcomes
  + eliminate/ reduce etiology of nursing diagnosis
  + Treatment of signs/symptoms/defining characteristics
  + Include:
    - Observations / assessments
    - Prevention
    - Treatments
    - Health promotion
* **Types of Nursing Interventions**
  + Direct care
    - an intervention performed by the nurse through interaction with the client
  + Indirect care
    - An intervention delegated by the nurse to another provider, or performed on behalf of the client (but not through direct interaction) such as interdisciplinary collaboration
  + Independent interventions
    - Activities that nurses can initiate themselves
    - Physical care, ongoing assessments, emotional support/comfort, teaching, referrals, etc.
  + Dependent interventions
    - Physician/HCP orders carried out by the nurse
  + Collaborative interventions
    - Collaboration with health team members – i.e. – coordination of physical therapy activities
* **Criteria for Choosing Appropriate Interventions** 
  + Safe and appropriate for the client’s age, health, and condition
  + Achievable with the resources available
  + Congruent with the client’s values, beliefs, and culture
  + Congruent with other therapies
  + Based on nursing knowledge and experience or knowledge from relevant sciences
  + Within established standards of care
* **Nursing Interventions Classification (NIC) See Table 13-6** 
  + Taxonomy of nursing interventions
  + Consists of three levels:
    - Level 1 domains
      * 1-7
    - Level 2 classes
      * A-Z and a-d
    - Level 3 interventions
      * Many possible interventions appropriate for one nursing diagnosis – not all of them are appropriate for every client, but they provide a basis for selection.
  + Each intervention includes:
    - A label (name)
    - A definition
    - A list of activities that outline key actions
  + Linked to NANDA diagnostic labels
  + Select appropriate intervention and customize
* **Sample**
  + GOAL - Reestablish urinary elimination with complete emptying of bladder within 8 hours of catheter removal.
    - 1. Offer assistance to bathroom q 3hours
    - 2. Offer glass of water every hour.
    - 3. Record I&O q4h.
    - 4. Provide privacy for voiding attempts.
    - 5. Run water for voiding attempts.
* **Practice**
  + Impaired skin integrity related to unknown etiology as evidenced by a 2cm intact lesion on left heel.
    - Goal?
      * Tissue Integrity; Client’s skin returns to normal structure and function
    - Interventions?
      * Seek dermatology consult to determine etiology of lesion.
      * Assess client for elevated body temperature (fever can indicate infection)
      * Assess client’s level of discomfort
      * Identify signs of itching and scratching
      * Reposition client q2h
      * Apply a wound barrier to prevent further injury
      * Apply appropriate topical medication as ordered
      * Maintain sterile dressing technique during wound care (to reduce risk of infection)
      * Encourage diet that meets nutritional needs (to promote healing)
      * Teach the patient or caregiver signs and symptoms of infection and when to notify the nurse/physician
  + The Nursing Care Plans book is GREAT for this kind of thing!!!
* **Rationale for interventions**
  + Reasons for recommending interventions
  + Example
    - DX Alteration in skin integrity related to decreased mobility as manifested by 3cm stage I area on sacrum
    - Intervention: Position Q2h with minimal time spent on back
    - **Rationale:** Prolonged pressure causes decreased tissue oxygen and nutrients to an area. Text, pp. 231-2

## The Nursing Process: Implementation

**Kozier Ch. 14 – Implementing and Evaluating**

**PPT – Critical Thinking and the Nursing Process**

* **Implementation** 
  + Performance of interventions
  + Based on 1st 3 phases
  + Individualized based on assessment data
  + Activities/ responses examined during evaluating phase
* **Successful Implementation**
  + Skills needed:
    - Cognitive skills (intellectual skills)
      * Problem solving
      * Decision making
      * Critical thinking
      * Creativity
    - Interpersonal skills
      * Interaction w/ one another
    - Technical skills
      * “hands-on” skills
      * Tasks, procedures, or psychomotor skills
      * Require knowledge & manual dexterity
* **Five Activities of the Implementing Phase** 
  + Reassessing the client
  + Determining the nurse’s need for assistance
  + Implementing nursing interventions
  + Supervising delegated care
  + Documenting nursing activities
* **Implementing Nursing Interventions: Guidelines** 
  + Evidence-based practice
  + Clearly understand interventions
  + Adapt activities to the individual client
  + Implement safe care
  + Provide teaching, support, and comfort
  + Be holistic
    - In other words, treat the patient as a whole – this involves honoring the client’s expressed treatment preferences
  + Respect the dignity of the client and enhance self esteem
  + Encourage active client participation
* **The Nursing Process - Evaluating** 
  + Collecting data related to the desired outcomes
  + Comparing the data with outcomes
  + Relating nursing activities to outcomes
  + Drawing conclusions about problem status
  + Continuing, modifying, or terminating the nursing care plan
* **Relationship of Evaluating to Other Phases** 
  + Success depends on the effectiveness of preceding phases
    - Assessing and nursing diagnosis must be accurate
    - Goals/desired outcome must be stated behaviorally to be useful
    - Without implementing phase, there would be nothing to evaluate
  + Evaluating and assessing phases overlap
* **Components of an Evaluation Statement** 
  + Conclusion
    - A statement that the goal/desired outcome was met, partially met, or not met
  + Supporting data
    - The list of client responses that support the conclusion
  + Example:
    - Goal met: Oral intake 300mL more than output skin turgor resilient; mucous membranes moist
* **Reviewing and Modifying the Care Plan (Table 14-1)**
  + Critique each phase of the nursing process
  + Check whether the interventions were
    - Carried out
    - Were unclear or unreasonable
  + Make necessary modifications
  + Implement the modified plan
  + Begin nursing process again
* **Evaluating Nursing Care Quality**
  + Quality Assurance
  + Quality Improvement
  + Audits
  + Peer Review
  + **Quality Assurance**
    - Ongoing, systematic
    - Evaluate & promote excellence in provision of health care
      * Agency
      * Country
      * Nurse
    - Evaluates:
    - Structure
    - Process
    - Outcome
  + **Quality Improvement**
    - Client care
    - Focus on process
    - Uses systematic approach to improve quality of care
    - Often focus on identifying and correcting a system’s problems
    - Also known as:
      * Continuous quality improvement (CQI)
      * Total quality management (TQM)
      * Performance improvement (PI)
      * Persistent quality improvement (PQI)
  + **Nursing audit**
    - Examination / review of record
      * Retrospective
      * Concurrent
  + **Peer Review**
    - Appraisal of quality of care / practice performed by other equally qualified nurses
      * Individual
      * Nursing audits
* **Evaluation**
  + Has the goal(s) been achieved?
  + Are the interventions working?
    - If not, why?
  + How will you modify the Plan?
* **Format to use: Care map**
  + Care map: Bring directions to class.